WELCOME TO NEIGHBORHOOD PLACE

DATE:

PLEASE PRINT

Name:	Date of Birth:
Complete Home Address:	Complete Mailing Address:
Number in Household:	Social Security Number:

Phone: ☐ Home ☐ Cell ☐ Alternate

Reason for Visit: ☐ New Applicant ☐ Return Visitor ☐ Follow up appt. with

APPLICATION INSTRUCTIONS

Neighborhood Place offers a variety of services. Complete the check boxes that best describe the services needed:

SERVICES NEEDED

Social Services		**Medicaid Services**	
Child Care Assistance Program (CCAP)	☐	Aging & Elderly Services (OAS)	☐
Child Support Services (SES)	☐	Disabled Adults-Disability Medicaid (DM)	☐
Family Independence Temporary Assistance Program (FITAP) – cash assistance	☐	LaMOMS (no cost Medicaid for pregnant women)	☐
Food Stamp Program (FSP)	☐	Louisiana Children's Health Insurance Program (LaCHIP)	☐
Kinship Care Subsidy Program (KCSP)	☐	Medicare Purchase Plan (MPP)	☐
LA Combined Application Project (LACAP)	☐	Medically Needy Program (MNP)	☐
Strategies to Empower People Program (STEP)	☐	Medicare Savings Program (MSP)	☐
Alternative Response	☐	TAKE CHARGE (TC) – no cost Medicaid family planning services	☐
Housing Services			
Emergency Shelter	☐	**Health Services**	
Energy Assistance	☐	Children's Special Health Services (CSHS)	☐
Homeless	☐	Family Planning	☐
Rental Assistance	☐	Head Lice Check	☐
Section 8	☐	HIV Testing	☐
Subsidized Housing	☐	Immunizations	☐
Utility Assistance	☐	Infant or toddler car seat	☐
Weatherization	☐	Lead Test	☐
		Pregnancy Test	☐
Behavioral Health Services		Sexually Transmitted Disease (STD)	☐
Alcohol	☐	TB Test	☐
Child abuse or neglect	☐	Women, Infants & Children (WIC)	☐
Child behavior	☐		
Depression – Feeling sad, hopeless, fearful	☐	**Employment Services**	
Drugs	☐	Initial Intake	☐
School attendance	☐	Career Assessment	☐
Attention Deficit Disorder (ADHD)	☐	Career Counseling	☐

Developmental Disabilities Services		Employment Services cont.	
Cash Subsidy Program	☐	Job Search	☐
Early Steps Program referral	☐	Work Readiness Seminars	☐
Home and Community-Based Waiver Services	☐	Earned Income Tax Credit (EIC)	☐
Individual & Family Support Program	☐	Help with resume (job application)	☐
Rehabilitation Services		**Education Services**	
Blind Services	☐	Adult Literacy - GED	☐
Deaf Services	☐	Even Start (family services for adult learners)	☐
Independent Living Services	☐	Behavioral Concerns	☐
Vocational Rehabilitation Services	☐	School Dropout Concerns	☐
Traumatic Head & Spinal Cord Injury	☐	Academic Concerns	☐
Other		School Health Concerns	☐
Community Diversion Programs	☐	Attendance Concerns	☐
Juvenile Court Services	☐	Truancy Concerns	☐
Transportation Assistance	☐	PALS After-School Enrollment	☐
Tribal Services	☐	Universal Pre-K Enrollment	☐
Service Needed but not Listed			
Write in here:	☐		
Write in here:	☐		

OTHER HOUSEHOLD MEMBERS		
NAME	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**

THANK YOU FOR ALLOWING US TO SERVE YOU!

STAFF USE ONLY

Worker Name: _____

Additional staff seen during this visit: _____

Limited English Proficiency: ☐ Yes ☐ No

Blind: ☐ Yes ☐ No

Hearing Impaired: ☐ Yes ☐ No

Limited English – Translation/Interpreter Services Utilized: ☐ Yes ☐ No

Agency of initial contact during this visit: ☐ DSS ☐ DHH ☐ DOE ☐ LWC ☐ OJJ ☐ Other

Agency referrals made to client during this visit: ☐ DSS ☐ DHH ☐ DOE ☐ LWC ☐ OJJ ☐ Other

Service referrals made to client during this visit:

Where did you hear about Neighborhood Place? Circle one

Newspaper Radio TV School Festival Mailer Poster @ Walmart, Grocery, etc.

Church Friend OFS OCS LRS DOE DHH OJJ LWC Other

RELEASE OF INFORMATION CONSENT FORM

I, _____, am seeking services from Neighborhood Place for ___myself, ___my family, ___my child (check all that apply). By signing this form, I am giving Neighborhood Place staff permission to communicate regarding services offered to me and/or my family. I understand that all records and information regarding services will be protected by regulations that govern the exchange of confidential information. I further understand that services may include an assessment of our needs and the development of a service plan to meet those needs.

It is understood that by authorizing the release of such information, it will be used for the sole purpose of providing and enhancing services to me, my family and/or my child and to avoid duplication between the agencies. The disclosure of information will be limited to staff at Neighborhood Place and within these organizations and will not be released to anyone else without my consent.

The agencies below have my written consent to share information of a confidential nature to the extent allowed by federal and state law and regulations unless I have indicated otherwise by putting my initials next to those agencies I want excluded.

Government, City, Private Non-profit Providers

Please initial those agencies you want excluded. Write in additional agencies you want *to add.*

_____ Louisiana Department of Health & Hospitals
_____ _____ Parish School System
_____ Louisiana Department of Social Services
_____ Louisiana Office of Juvenile Justice
_____ Louisiana Department of Education
_____ Louisiana City/Parish Government

_____ Louisiana Public School System
_____ Louisiana Workforce Commission

_____ Other **Agencies**

_____

Please initial the information you wish to have excluded from this authorization. Write in information you want to add to this authorization.

___ The full name and other identification of myself my family or my child
___Records pertaining to juvenile justice proceedings, including arrests/adjudication
____ Social and educational history and observations
____Records pertaining to child in need of care/ certification for adoption proceedings in juvenile court

___Treatment, services or education plans
___ Recommendations to other providers
___ Medical records and information pertaining to medical history, physical condition, services rendered and treatments given
___Medical records and information and information pertaining to mental health

Other Records: _____

I have read and understand the contents of this form; I have a copy and I agree to its provisions with the exception of any items I initialed above.

This authorization to receive services from the above agencies and to exchange confidential information shall remain in effect for a period of twelve (12) months. I understand that this release may be revoked by me at any time if requested in writing, but understand my records may have been released and re-released to others before I request that this consent be revoked.

Signature of self or children **Date** **Witness signature** **Date**

*** Parent/Guardian (please list children's names)**_____

THIS DOCUMENT DOES NOT AUTHORIZE THE RELEASE OF INFORMATION RELATIVE TO HISTORY OF DRUG/ALCOHOL TREATMENT, SEXUALLY TRANSMITTED DISEASES, AND/OR HIV STATUS. PURSUANT TO FEDRRAL LAW, PROTECTED HEALTH INFORMATION MAY BE RELEASED WITHOUT YOUR AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, AUTHORIZATION IS NOT REQUIRED TO COMPLY WITH LAWS REGARDING MANDATORY REPORTING OF SUSPECTED ABUSE OR NEGLECT OR ASSESSMENT THAT THERE IS A DANGER OF SERIOUS HARM TO SELF OR OTHERS.